

6. Average cost per diem for inpatient general routine services (\$162,885 routine cost net of private room cost differential + 1,100 patient days), \$148.08.  
*Medicare general routine service cost.*  
 7. Total routine per diem cost applicable to Medicare (\$148.08 average cost per diem × 470 Medicare private and semi-private patient days), \$69,598.  
 8. Total private room cost differential applicable to Medicare (\$21.15 average per diem private room cost differential × 20 medically necessary private room days), \$423.  
 9. Medicare inpatient general routine service cost (\$423 Medicare private room cost differential + \$69,598 Medicare cost of general routine inpatient services), \$70,021.

(2) *Carve out method.* The following illustrates how apportionment is determined in a hospital reimbursed under the carve out method (subject to the private room differential provisions of paragraph (a)(1)(ii) of this section):

HOSPITAL K [Determination of cost of routine SNF-type and ICF-type services and general routine hospital services <sup>1</sup> ]			
Facts	Days of care		
	General routine hospital	SNF-type	ICF-type
Total days of care .....	2,000	400	100
Medicare days of care ...	600	300	
Average Medicaid rate ...	N/A	\$35	\$20
Total inpatient general routine service costs: \$250,000			

Calculation of cost of routine SNF-type services applicable to Medicare:  
 $\$35 \times 300 = \$10,500$   
 Calculation of cost of general routine hospital services:  
 Cost of SNF-type services:  $\$35 \times 400$  ..... \$14,000  
 Cost of ICF-type services:  $\$20 \times 100$  ..... 2,000  
 Total ..... \$16,000  
 Average cost per diem of general routine hospital services:  
 $\$250,000 - \$16,000 \div 2,000 \text{ days} = \$117$   
 Medicare general routine hospital cost:  
 $\$117 \times 600 = \$70,200$   
 Total Medicare reasonable cost for general routine inpatient days:  
 $\$10,500 + \$70,200 = \$80,700$

[51 FR 34793, Sept. 30, 1986, as amended at 59 FR 45401, Sept. 1, 1994; 61 FR 51616, Oct. 3, 1996; 61 FR 58631, Nov. 18, 1996]

§ 413.56 [Reserved]

Subpart E—Payments to Providers

§ 413.60 Payments to providers: General.

(a) The fiscal intermediaries will establish a basis for interim payments to each provider. This may be done by one of several methods. If an intermediary is already paying the provider on a cost basis, the intermediary may adjust its rate of payment to an estimate of the result under the Medicare principles of

reimbursement. If no organization is paying the provider on a cost basis, the intermediary may obtain the previous year's financial statement from the provider and, by applying the principles of reimbursement, compute or approximate an appropriate rate of payment. The interim payment may be related to the last year's average per diem, or to charges, or to any other ready basis of approximating costs.

(b) At the end of the period, the actual apportionment, based on the cost finding and apportionment methods selected by the provider, determines the Medicare reimbursement for the actual services provided to beneficiaries during the period.

(c) Basically, therefore, interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period. Interim payments will be made as often as possible and in no event less frequently than once a month. The retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than on an estimated basis.

§ 413.64 Payments to providers: Specific rules.

(a) *Reimbursement on a reasonable cost basis.* Providers of services paid on the basis of the reasonable cost of services furnished to beneficiaries will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of a reporting period.

(b) *Amount and frequency of payment.* Medicare states that providers of services will be paid the reasonable cost of services furnished to beneficiaries. Since actual costs of services cannot be